Brian Shwer, DPM
564 E. Goodman Road
Southaven, MS 38671
(662) 349-7333

Last name _____First _____ M.I. _____ Patient's Date of Birth_____

Social Security # _____Address _____

Home # (____)-_____Cell# (___) _____Email address _____

Age_____ Gender ____M___F Marital Status : M_____S_____D_____ W_____ Race _____

How do you prefer to be contacted with appointment details: email____ text____voice____

Employer _____Address _____ Phone# _____

PCP Name and Date Last Seen _____Phone#_____

Emergency Contact (Name, Number, Relation) _____

INSURANCE INFORMATION ***(Please complete all blanks.)***

Primary Insurance:

Name _____Address _____ Phone # _____

City, State, Zip _____ ID # _____Group # _____

Policy Holder's Name (if other than patient) _____Relation to patient _____

Policy Holder's Date of Birth _____ Is pre-certification and/or referral authorization required? _____

Policy Holder's SS# _____

Secondary Insurance:

Name _____Address _____ Phone # _____

City, State, Zip _____ ID # _____Group # _____

Policy Holder's Name (if other than patient) _____Relation to patient _____

Policy Holder's Date of Birth _____ Is pre-certification and/or referral authorization required? _____

Policy Holder's SS# _____

I authorize release of any medical information necessary to process this claim. I also authorize Medicare and/or other insurance payment of medical benefits to Dr. Shwer for services provided to me. I understand that I am financially responsible to Dr. Shwer for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverage's are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

I also agree to give Medical Insurance Filing Services, Inc. authorization to file insurance for medical claims on behalf of Dr.Shwer.

Patient's Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT
I HAVE RECEIVED THIS PRACTICE'S NOTICE OF PRIVACY PRACTICES WRITTEN IN PLAIN LANGUAGE. THE NOTICE PROVIDES IN DETAIL THE USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION THAT MAY BE MADE BY THIS PRACTICE, MY INDIVIDUAL RIGHTS, HOW I MAY EXERCISE THESE RIGHTS, AND THE PRACTICE'S LEGAL DUTIES WITH RESPECT TO MY INFORMATION.
I UNDERSTAND THAT THIS PRACTICE RESERVES THE RIGHT TO CHANGE THE TERMS OF IT'S NOTICE OF PRIVACY PRACTICES, AND TO MAKE CHANGES REGARDING ALL PROTECTED HEALTH INFORMATION RESIDENT AT, OR CONTROLLED BY, THIS PRACTICE. I UNDERSTAND I CAN OBTAIN THIS PRACTICE'S CURRENT NOTICE OF PRIVACY PRACTICES UPON REQUEST.
I GIVE PERMISSION FOR THE STAFF OF THIS PRACTICE TO LEAVE MESSAGES REGARDING MY APPOINTMENTS, ACCOUNT STATUS ETC ON MY ANSWERING MACHINE/ VOICE MAIL OR WITH PERSONS ANSWERING MY PHONE.

PATIENT NAME : _____ DATE OF BIRTH: _____

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT IF SIGNED BY A PERSONAL REPRESENTATIVE OF THE PATIENT:

_____

Agreement/ Conditions of Treatment

This is an agreement between Dr. Brian Shwer, summarizing our understanding of the conditions under which I consent to treatment of my foot and/ or ankle condition(s). I understand that Dr. Shwer will use his best skill and judgment to accomplish the desired result, but that Dr. Shwer cannot and does not warrant or guarantee such result; also that his forecast of the length of time involved in therapy and/ or recovery from any treatment including but not limited to surgery, the manner of recovery and the possible complications or untoward results is based upon the usual and average response in cases similar to mine, but that it is not a promise, since healing is an individual process and my result/ response may be different than the usual. I promise full cooperation with Dr. Shwer and staff in my treatment, whether by surgical or non-surgical means. I understand that if I do not follow the instructions given to me by Dr. Shwer and/ or their staff concerning my care and treatment the outcome of my care and treatment could be put in jeopardy and a bad result may occur. I understand that the above medical information is necessary in order for Dr. Shwer to be able to provide me with medical care in the most safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, I give my permission to ask the respective healthcare provider or agency for that information and I release them to provide that information for continuation of medical care. I understand that it is imperative that I advise the office immediately of any changes in my health status or medications.

Patient Name _____
Patient OR Guardian Signature _____ Date: _____
Witness _____

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HEALTH HABITS

Do you smoke? yes no **if yes, # of packs/ day** _____ **for how long**_____

Past smoker? yes no **how much for how long** _____ **when did you quit?** _____

Do you drink Alcohol? yes no, **if yes:** rarely, 1-2 drinks per week, 2 drinks per day, more than 2 daily

Employment Conditions: not actively employed (retired, disabled, unemployed, homemaker)
sits all day at work stands and/or walks all day at work

Do you drink caffeine? Yes No **If yes how much per day?** _____
Do you utilize street drugs? Yes No
Circle if your work exposes you to: Stress Heavy Lifting Hazardous Substances

HEALTH HISTORY

Circle all that you have or have had problems with:

General Unexplained Weight loss, Unexplained weight gain, Fever, Chronic Fatigue, Anemia, Bruising Easily, Allergies
Eyes: Failing Vision, Eye Infections, Double Vision, Blurry Vision
Cardiovascular: Chest Pain, Dizziness/ Fainting, Palpitations, Swollen Ankles, Leg Pain, Varicose Veins, Circulatory Problems, numbness in feet/ extremities, tingling in feet, tingling in the hands
Respiratory: Chronic Cough, Asthma, Shortness of Breath, COPD, other lung disorder
Musculoskeletal: Arthritis or Joint Pain, Back Pain, Muscle Pain, hand pain, foot pain, hip pain, leg pain, shoulder pain
Neurological: Convulsion, Seizure, Tremor (shaking), Muscle Weakness, Numbness, Tingling, Frequent Headaches
Skin: Rashes/ Hives, Itching, skin disorder, Ulcers, Fissures, Callous, Corn
Psychiatric: Nervousness, Depression, Anxiety, Memory Loss, Trouble Sleeping

Have you had any of these conditions?

High Blood Pressure	**Hepatitis C**	**Stroke**	**Chronic Bronchitis/ COPD**
Low Blood Pressure	Epilepsy	Renal Failure	High Cholesterol
Kidney Problems	Arthritis	Back Pain	Alcoholism
Migraines	Peripheral Vascular Disease	Thyroid Disease	Illegal Drug Use
Hepatitis A	Diabetes (IDDM/ NIDDM)	Asthma	HIV+
Hepatitis B	Cancer Type and status_____		Neuropathy

Is there a family history (blood relative) of the following:

Heart Disease	**Diabetes**	**Cancer**	**Stroke**	**Bleeding Disorder**
Arthritis	Gout	Neurological disorder	Circulation Problems in feet or legs	

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Effective January 1, 2010 All medical providers are required to report to the Division of Public Health any race and ethnicity data provided by the patient. Please circle the appropriate response below:

Race: American Indian, Asian, Black or African American, Native Hawaiian or Pacific Islander, Caucasian, Patient declined or unavailable
Ethnicity: Non-Hispanic, Hispanic, Patient declined or unavailable

What language do you prefer? _____

WE DO NOT ACCEPT WORK COMP, LEGAL, OR 3RD PARTY LIABILITY CASES.

If the patient needs to be seen for an on the job injury or third party liability injury you need to follow the proper protocol for reporting this. You will then be referred by them to a physician that accepts these cases.

Please provide any details regarding any injury or possible injury.

_____
_____
_____
_____

What size shoe does the patient wear? _____
What is the patient's weight? _____
What is the patient's height? _____

MEDICAL INFORMATION
(THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH)

What is the reason for your visit today :

_____
_____

How long has it been bothering you? _____
Describe any past problems with your feet and/or ankles and summarize what treatment was performed:

_____
_____
_____

List any medications including supplements that you are currently taking:

_____
_____
_____

List any medications that you are allergic to and the reaction you have:

_____
_____

Are you allergic to Tape, Adhesive, Iodine, Latex or anesthetics?

_____

List any surgeries that you have had

_____
_____
_____
_____

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CONSENT FOR TREATMENT AND CARE

I, the undersigned, do hereby agree and give my consent for Dr. Shwer to furnish medical care and treatment to myself or _____ which is considered necessary and appropriate in diagnosing or treating my/their physical condition.

STATEMENT OF FINANCIAL RESPONSIBILITY

All services rendered are the responsibility of the patient. As a courtesy to our patients, we will file with your insurance carrier. The patient is responsible for all fees, regardless of insurance coverage or the usual and customary fees provided by your insurance company. Payment is expected at time of treatment unless prior arrangements have been made with our office. I understand that I will be responsible for any costs incurred as a result of my account being turned over to a collection agency or attorney. I understand that I will be responsible for a service charge for any returned checks.

INSURANCE AUTHORIZATION AND BENEFITS ASSIGNMENT

I hereby authorize Dr. Shwer to release all information necessary, including medical records, requested by insurance companies with whom I have coverage and any public agency or its agents to secure payment for myself or my dependents. I hereby authorize payment of benefits to be made directly to The Southaven Foot Clinic for services provided to me or my dependents.

MEDICARE ONE-TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Shwer for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services.

MEDIGAP AUTHORIZATION

I request that payment of authorized Medigap benefits be made on my behalf to Dr. Shwer for any services furnished me by that provider. I authorize any holder of medical information about me to release any information needed to determine those benefits or the benefits payable for related services to my Medigap carrier.

CLAIM FILING CONSENT

I also agree to give Medical Insurance Filing Services, Inc. authorization necessary to file insurance for medical claims on behalf of Dr. Shwer.

Print Name _____

Patient's Signature _____ Date _____